VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

August 31, 2012

Ms. Rose Mary Mayhew, Administrator
Belaire Quality Center
35 Bel-Aire Drive
Newport, VT 05855-4953

Provider #: 475049

Dear Ms. Mayhew:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **July 18, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota; RN
Licensing Chief

PC:ne

Enclosure

RECEIVED
Division of
AUG 17 12
Licensing and Protection

PRINTED: 08/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475049	A. BUILDING _____ B. WING _____	07/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELAIRE QUALITY CENTER	35 BEL-AIRE DRIVE NEWPORT, VT 05855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site recertification survey was completed from 7/16/12 to 7/18/12 by the Division of Licensing and Protection. The following are regulatory findings.	F 000	Bel-Aire Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of one resident (Resident #86) identified in the sample. The findings include: 1. Per record review, Resident #86 was admitted on 5/24/12 with diagnoses that include; depression, Cerebral Vascular Accident (CVA), flaccid hemiplagia on the non dominate side, and difficulty walking. Per review of the nurses notes, the notes indicate that Resident #86 is frequently non compliant with care during the time frame of 5/24/12 to 7/18/12. The notes indicate that on 22 occasions from 5/24/12 to 7/18/12, Resident #86 refused to take his/her oral medications including an antidepressant medication ordered to help treat Resident #86 diagnoses of depression and Plavix and Lovenox (medications used to reduce risk of stroke in patients that have had a CVA).	F 250	F-250 Resident #86 now has a behavioral care-plan for 'non compliance' due to medication refusals despite this being a lifelong belief that it is best not to take any medications ever, this was completed 6-17-2012. Current and all new admissions will have a care plan developed for non compliance as appropriate. Licensed nursing staff will receive re education on development of care plans regarding non compliance. Effectiveness of the re education/development of care plan will be monitored weekly at the CAR (customer at risk meeting) and reviewed at the CQI meeting. Over-site by the	8/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rose Mary Mayhew — TITLE: Administrator — (X6) DATE: 8/13/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PMC

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F 250	Continued From page 1 The physicians orders indicate that on 7/10/12, 3 of Resident #86's medications were discontinued for failure of resident to take medication. Per the notes, Resident #86 indicates to staff that he/she "doesn't take dope", and he/she "will take the medication [he/she] wishes to take". The nurses notes also indicate that Resident #86 is non compliant with ordered diet of pureed food and was noted to be eating donuts provided by family. The nurse's notes indicate that Resident #86, "refuses to cooperate with repositioning by staff, and refuses to utilize positioning devices." The nurses notes indicate on 6/10/12 that Resident #86 was talking of sadness in his/her marriage, and was "difficult to reason with and redirect." The notes indicate that Resident #86 verbally threatens staff when the staff attempts to assist him/her and that Resident #86 refuses to call for assistance when needing help which caused resident to sustain a fall from the toilet on 7/14/12. The notes indicate that Resident #86 was noted to have and admitted to staff of "purposefully urinating on self." Resident #86 on 6/12/12 indicated to staff that he/she was unhappy at the facility. Per review of the care plan meeting notes dated 6/12/12, family and resident were educated again on importance of taking prescribed medications and it was discussed with family that medication compliance was key if the resident is to accomplish his/her goal and go home. Resident #86 indicated in the meeting that he/she will continue with noncompliance. Per review of the comprehensive admission assessment (MDS) dated 5/31/12; Resident #86 has no cognitive impairment. Per review of the	F 250	Director of Nursing and Administrator F250 POC accepted 8/30/12 MHiggins RN Pmc	

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F 250	Continued From page 2 comprehensive care plan, there was no evidence that a care plan was developed to address Resident #86's refusing of medications, non compliance with seeking out assistance, the behavior of verbally threatening staff and purposefully urinating on self. Per interview with the Director of Nursing Service (DNS), on 7/18/12 he/she indicated that he/she could not locate a care plan that addressed Resident #86's non compliant behaviors, or ways to prevent and decrease reoccurrence. Per interview with the Social Service Director on 7/18/12 at 2:07 PM, he/she confirmed that no behavior care plan was developed since admission on 5/24/12 to address, prevent and decrease reoccurrence of noncompliant behaviors, verbal threats and or other documented behaviors. The SS Director also confirmed that no recommendation had been made regarding the potential need for psychological services and no discussion had taken place offering psychological services to Resident #86.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	F 279 Resident #86 now has a behavioral care-plan for 'non compliance' Current and all new admissions will have a care plan developed for non compliance as appropriate. Licensed nursing staff will receive re education on development of care plans	8/14/12

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F 279	Continued From page 3 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to develop a comprehensive care plan for 1 resident (Resident #86) identified in the sample regarding his/her refusal of care and services. The findings include: 1. Per record review, Resident #86 was admitted on 5/24/12 with diagnoses that include; depression, Cerebral Vascular Accident (CVA), flaccid hemiplegia on the non dominate side, and difficulty walking. Per review of the nurses notes, the notes indicate that Resident #86 is frequently non compliant with care during the time frame of 5/24/12 to 7/18/12. The notes indicate that on 22 occasions from 5/24/12 to 7/18/12, Resident #86 refused to take his/her oral medications including an antidepressant medication ordered to help treat Resident #86 diagnoses of depression and Plavix and Lovenox (medications used to reduce risk of stroke in patients that have had a CVA). The physicians orders indicate that on 7/10/12, 3 of Resident #86's medications were discontinued for failure of resident to take medication. Per the notes, Resident #86 indicates to staff that he/she "doesn't take dope", and he/she "will take the	F 279	regarding non compliance. Effectiveness of the re education/development of care plan will be monitored weekly at the CAR (customer at risk meeting) and reported on to the CQI meeting. Over-site by the Director of Nursing and Administrator F279 POC accepted 8/30/12 MHiggins RN/QMC	

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F 279	Continued From page 4 medication [he/she] wishes to take". The nurses notes also indicate that Resident #86 is non compliant with ordered diet of pureed food and was noted to be eating donuts provided by family. The nurse's notes indicate that Resident #86, "refuses to cooperate with repositioning by staff, and refuses to utilize positioning devices." The nurses notes indicate on 6/10/12 that Resident #86 was talking of sadness in his/her marriage, and was "difficult to reason with and redirect." The notes indicate that Resident #86 verbally threatens staff when the staff attempts to assist him/her and that Resident #86 refuses to call for assistance when needing help which caused resident to sustain a fall from the toilet on 7/14/12. The notes indicate that Resident #86 was noted to have and admitted to staff of "purposefully urinating on self." Resident #86 on 6/12/12 indicated to staff that he/she was unhappy at the facility. Per review of the care plan meeting notes dated 6/12/12, family and resident were educated again on importance of taking prescribed medications and it was discussed with family that medication compliance was key if the resident is to accomplish his/her goal and go home. Resident #86 indicated in the meeting that he/she will continue with noncompliance. Per review of the comprehensive admission assessment (MDS) dated 5/31/12; Resident #86 has no cognitive impairment. Per review of the comprehensive care plan, there was no evidence that a care plan was developed to address Resident #86's refusing of medications, non compliance with seeking out assistance, the behavior of verbally threatening staff and	F 279		

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F 279	Continued From page 5 purposefully urinating on self. Per interview with the Director of Nursing Service (DNS), on 7/18/12 he/she indicated that he/she could not locate a care plan that addressed Resident #86's non compliant behaviors, or ways to prevent and decrease reoccurrence. Per interview with the Social Service Director on 7/18/12 at 2:07 PM, he/she confirmed that no care plan was developed since admission on 5/24/12 to address, prevent and decrease reoccurrence of noncompliant behaviors, verbal threats and or other documented behaviors.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to implement the care plan for 1 of 20 residents in the stage 2 sample (Resident #39). The findings include: Per multiple observations of Resident #39 on 7/17/12 and 7/18/12, staff failed to ensure that the head of the bed was kept at 90 degrees after drinking. Per review of the care plan dated 04/25/12 and speech language therapy recommendations, the resident was to have a straw with liquids, staff to feed/snacks, and for the resident to stay upright 30 minutes following a	F 282	F 282 Resident #39 care plan has been reviewed with nursing staff, as well as re-education given in regards to following care plans. Any resident that requires the HOB to be elevated during and after po consumption will be reviewed with staff. Supervisors/Charge nurses will monitor this daily, as will DNS during walking rounds. Effectiveness of this re-education will be monitored weekly at the Customer At Risk meetings and reported on at the CQI meeting. Over-site by the Director of Nursing and Administrator.	8/14/12

F282 POC accepted 8/30/12 MHiggansRN/ RNC

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F 282	Continued From page 6 meal/snack at 90 degrees Per observations on on 07/17/12 and on 07/18/12 at 2:30 PM and 1:55 PM, respectively, the resident received water and/or a milkshake but staff failed to raise and/or keep the head of the bed at at least 90 degrees as care planned. Per interview on 07/18/12 at 2:15 PM, 2 LNA (Licensed Nursing Assistant) staff stated and confirmed that head of the bed was not at 90 degrees because "[resident] is so bony that [s/he] doesn't stay up for long". Per interview at that time, the unit nurse confirmed that the care plan was not implemented.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and closed record review, the facility failed to assure that 2 applicable residents with a history of multiple falls received care and treatments to prevent accidents and/or failed to provide appropriate post fall care. (Resident #25 & #86) Findings include: 1. Per observation, record review and interview the facility failed to provide an assistance device for Resident #25, who has a history of falls. Per	F 323	F 323 Resident #25 had a soft touch call bell installed 6-17-12. Re-education to the nursing staff on the process of communicating nursing needs to maintenance will be done. Supervisor/Charge Nurse will monitor daily at morning meeting. Effectiveness of the re-education will be reviewed weekly at the Customer At Risk meeting and reported on to the CQI meeting. Resident #25 care plan has been reviewed with nursing staff, as well as re-education given in regards to following care plans. Any resident that requires the walker/device to be located in a specific area will be reviewed with staff. Supervisors/Charge	8/14/12

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F 323	Continued From page 7 observations of Resident #25's room on 07/17/12 at 11:57 AM and 07/18/12 at 11:59 AM a regular call light bell with red tape surrounding the button and a walker, not near the bed but near the bathroom door, several feet away, was noted. Per review of the care plan on 07/17/12, which was revised after a fall, dated 07/05/12, directed staff to keep walker at bedside when in lounge chair and call bell to be changed to a touch bell when one is available as resident does not ring for staff. Per interview with maintenance on 07/18/12 at 8:30 AM stated s/he was not aware of the request for a new touch call light and is able to get a new call touch pad within 24 hours of knowing. In addition, there was no request slip nor a record in the repair log book for this item. Per interview on 07/18/12 at 12:36 PM the unit nurse confirmed that the assistance devices were not available at all times. 2. Per review of the medical record on 7/18/12, Resident #86 was admitted to the facility on 5/24/12 with diagnoses that include: Cerebral Vascular Accident (Stroke), flaccid hemiplegia on the non dominate side, and difficulty walking. Per review of the medical record, Resident #86 fell out of bed on 7/6/12 and was found on the floor. Also on 7/14/12, Resident #86 fell from the toilet in the bathroom. Per review of the nursing assessment dated 5/24/12, it indicates that Resident #86 has left sided paralysis in upper and lower extremities. Per review of the 6/21/12 comprehensive assessment (MDS), the MDS	F 323	nurses will monitor this daily, as will DNS during walking rounds. Effectiveness of this re-education will be monitored weekly at the Customer At Risk meetings and reported on at the CQI meeting. Resident #86 had a fall risk TCP in place since admission 5-24-2012. Resident #86 had no prior incident involving falling from the toilet prior to 7-14-2012, had used the facilities many times and was given privacy at her request, the intervention to not leave un attended was implemented 7-14-2012 and had no falls since. The 7-14-2012 fall did not result in any type of injury. Fall risk care plans for all residents including new admission will be reviewed within 24 hours of admission for appropriate interventions. Effectiveness of the TCP will be reviewed weekly at the Customer At Risk meeting and reported on at the CQI meeting. Over-site by the Director of Nursing and Administrator F323 POC accepted 8/30/12 Mitigation/RM Amc	

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F 323	Continued From page 8 indicates that Resident #86 had upper and lower extremity impairment, Resident #86 is "not steady only able to stabilize with staff assist from sitting to standing", "needs extensive assist of one staff member when toileting", is "frequently incontinent of bowel and bladder" and is an "extensive assist of 2 staff members when moving on and off the toilet and only able to stabilize on the toilet with staff help". Per review of the nursing notes from admission on 5/24/12 to 7/18/12 indicates that Resident #86 has incidences of being non compliant with asking for assistance. Per review of the Physical Therapy Assessment dated 5/29/12, it indicates that Resident #86 needs fall precautions, has poor sitting balance and poor standing balance. The assessment also indicates that Resident #86 is unable to do transfers and has impaired range of motion and strength on both the left upper and lower extremities. Per review of the Occupational Therapy Admission Assessment dated 5/29/12 it also indicates that on admission Resident #86 is a maximum assist with transfers and positioning during toileting. The assessment also indicates that Resident #86 also has impaired strength and range of motion on the left side. Per interview with the OT/PT Program Manager on 7/18/12, he/she confirmed that on admission and currently, Resident #86 is impaired on the left side upper and lower extremities, he/she has been and remains at risk for falls, was and continues to be a maximum assist for toileting, transfers and positioning and should not be in the bathroom unattended since admission. The PT/OT Director confirmed that Resident #86 was not care planned to not be left alone in the bathroom until after the fall on 7/14/12. Per	F 323		

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F 323	Continued From page 9 review of the care plan titled "Resident is at risk for falls" initiated on 5/24/12, Resident #86 was to be monitored for and assisted with toileting needs. Per interview with the Director of Nursing Services on 7/18/12 at 12:23 PM, he/she indicated that review of the medical record indicates that Resident #86 was a fall risk from admission and that the documentation from PT/OT indicates since admission that Resident #86 was non able to toilet his/herself without assistance and was not able to maintain safe and proper positioning while on the toilet without assistance. The DNS also confirmed that the care plan for "At risk for falls" was not updated with the intervention of "do not leave resident unattended in the bathroom" until after the fall on 7/14/12.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to store all food for resident consumption under sanitary conditions. Findings include:	F 371	F 371 All dented cans were removed from the supply area immediately. Sandwich meat which was still frozen was immediately returned to the cooler. Re-education will be provided to all staff regarding proper food storage/defrosting frozen items according to SafeServ criteria. Monitoring of these practices will be done weekly and on going by the FSS and lead cooks in the absence of the FSS. Over site by the FSS and Administrator	8/14/12

F371 POC accepted 8/30/12 MHiggins RN/PMC

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F 371	Continued From page 10 Per observation, during tour of the kitchen and dry goods storage areas at 10:53 AM on 07/17/12, the following observations were made and confirmed by the FSS (Food Services Supervisor) who was present during the tour: a) Several large dented cans of of tuna, pear slices and pudding were noted on the shelves containing foods to be served to the residents. The FSS stated "that [dented cans] should've been put in my office". b) Sandwich meat (ham & turkey) was observed defrosting on the small vegetable sink. When asked by the nurse surveyor about defrosting the staff stated "I pulled it out this morning to defrost a little but I guess it should be defrosted in the walk in refrigerator". The staff person then returned the meat to the refrigerator.	F 371		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475049	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 7/18/2012
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 283	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS

When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.

This REQUIREMENT is not met as evidenced by:
Based on record review and confirmed through staff interview, the facility failed to provide a recapitulation of the resident's stay and/or a final summary of the resident's status at the time of discharge for 2 of 21 residents in the sample (Residents #56 & #69). Findings include:

1. Per review of a closed record on 07/17/12 at 2:42 PM, Resident #69's discharge check list stated 'home w/ caregiver and other HHA'. However, there was no recapitulation of the resident's treatments or identified specific resident needs after discharge such as personal care, sterile dressings, and physical therapy, as well as describe resident/caregiver education needs and ability to meet care needs after discharge. Per interview at that time, social service coordinator stated that "the new closed records are going to have better system" and confirmed the chart did not have the complete discharge components.

2. Per medical record review on 7/18/12, Resident #56 was admitted to the facility on 3/9/12 with diagnosis that included cellulitis, diabetes, ankle ulcers, anemia, hypertension, hyperkalemia, hyperlipidemia, anxiety, pain, neuropathy and contractures of the foot and ankle. Per review of the skin integrity reports, Resident #56 had a surgical wound on the left leg, arterial ulcers on the left lateral ankle, left medial ankle and left distal ankle that were present on admission and were actively being assessed and treated with the application of topical dressings every 7 days and as needed through Resident #56's stay at the facility up to the day of discharge on 4/4/12. The nurse's notes also indicated that Resident #56 had a central line catheter that required flushes every 12 hours by staff from admission up to discharge on 4/4/12. Per review of the physician's orders and medication administration records from 3/9/12 to 4/4/12, Resident #56 was receiving several medications including Actonel which requires a resident to take with a full glass of water on an empty stomach and to remain upright after taking for 30 minutes, Fentanyl patch (for pain relief) that is required to be placed on a resident for 12 hours and then removed, Florastor taken three times a day while on antibiotics and ten days after antibiotic is stopped, many medications that are to be given twice daily and diabetic medications that required finger sticks before meals and at bedtime. Per review of the physical and occupational therapy notes from 3/9/12 to 4/4/12, Resident #56 was to utilize a wheeled walker and to elevate extremity to address edema in lower extremity.

Per review of the medical record on 7/18/12 there was no evidence that the facility provided a recapitulation of the stay for Resident #56 or any discharge summary indicating course of stay, medication and

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475049	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 7/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELAIRE QUALITY CENTER	**35 BEL-AIRE DRIVE NEWPORT, VT**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 283	Continued From Page 1 administration, follow up instructions, or any equipment that may be needed upon discharge. Per interview on 7/18/12 with the facility's Corporate Clinical Services Director, he/she confirmed on 7/18/12 at 12 noon that there was no evidence in the medical record of a recapitulation of the stay for Resident #56 or any discharge summary indicating course of stay, medication and administration, follow up instructions, and any equipment that may be needed upon discharge.